Associates in Pediatric Care-Hampton, LLC
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Authorization to Disclose Health Information and Release Records

1. **Patient's Name** _____ **DOB** _____
   Last, First, M.I. **MM/DD/YEAR**

   Patient's Address _____ _____
   Street Address **City, State, Zip Code**

2. **Information Released From:** _____
   Name of Health Care Provider

   _____
   Address **City, State, Zip Code**

   _____
   Office Phone # **Office Fax #**

3. **Information Released to:** **Associates in Pediatric Care-Hampton, LLC**
   2101 Executive Drive, Suite 160
   Hampton, VA 23666

4. **Reason for Records to be Disclosed:** **Check one** **Continued Care** ☐ **Personal Use** ☐

5. **Purpose of Disclosure:**

   ☐ **Immunization Only**

   ☐ **All records**

   ☐ **Other (Specify)** _____

6. **I hereby authorize disclosure of the health information for the above named individual.**

Parent/Guardian _____ _____
Signature **Print Name**

_____
Date

The information contained in this facsimile may contain personal and/or privileged information and should be treated as "FOR OFFICIAL USE ONLY."